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Arizona Department Of Insurance

Triennial Report Regarding the Accountable Health Plan Laws

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To

The Honorable Jane Dee Hull
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The Honorable Randall Gnant
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Speaker of the House

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INTRODUCTION

This is the Department of Insurance's triennial report to the legislature on the effectiveness of Arizona's Accountable Health Plan Law, set forth in Title 20, Chapter 13, of the Arizona Revised Statutes. The report is prepared pursuant to ARS §20-2319. Accordingly, it addresses, among other things:

- The impact of guaranteed issue and the premium tax exemption on premium rates and plan availability.
- The overall impact of the law on the small employer health insurance marketplace.
- Data on the effect of similar market reform laws in other states.
- Recommendations for:
  - Actions to improve the overall effectiveness, efficiency and fairness of the small employer health insurance marketplace;
  - Market conduct; or
  - Other regulatory standards or action.

This report also provides information and analysis of two alternative models for coverage for the uninsured in the small group market. In addition, it discusses the potential impact on the small group market of possible federal preemption, particularly with regard to Association Health Plans. Finally, it reviews the effectiveness of Arizona's Small Employer Reinsurance Program.

EXECUTIVE SUMMARY

Arizona's Accountable Health Plan laws have been in place for almost ten years, since the legislature enacted Senate Bill 1109 in 1993. Guaranteed issue requirements, along with the requirement that any accountable health plan (AHP) that wants to be in the medium or large market must also be in the small market have increased and protected availability.

Availability is continually undermined, however, by diminishing affordability. Price remains the greatest obstacle to coverage. The limited laws directed at controlling rates do not appear to have been effective and are difficult to administer. The premium tax exemption does not appear to have a significant impact on the affordability of coverage for small groups.

Even when insurance is affordable, small employers find that a variety of practical factors, such as administrative problems, the lack of competition in a shrinking market, product limitations and compliance issues interfere with obtaining coverage.

There are many health care coverage models available across the nation and being considered in Arizona. One of these, the high risk pool, has the potential to succeed in covering a very limited number of otherwise uninsurable people, provided it is carefully structured and adequately funded. Other models, such as the healthcare purchasing cooperative, have the much broader purpose of reducing the overall number of uninsured. They have not as a rule succeeded, generally because they do not attract enough of the uninsured population.

Federal preemption poses a threat to Arizona's progress with regard to small group reforms. One example of this is the concept of the Association Health Plan, which could deny Arizona consumers certain protections and undermine the economic foundation of the existing small group market.

Finally, the Small Employer Reinsurance Program provides little apparent benefit to consumers or insurers in return for the public resources and industry costs required to operate it.

BACKGROUND

Legislative History

Under the AHP laws, any licensed insurer that wants to be active in the group health insurance market in Arizona must first qualify as an accountable health plan (AHP). A.R.S. § 20-2301(A)(1). This includes insurers with products ranging from HMOs to traditional indemnity policies. The AHP laws reformed the group health insurance market by instituting guaranteed issue requirements aimed at improving the availability of group health insurance to small employers. The reforms also restricted premium rates charged to small employers by creating a rating band, within which small group rates must remain.

The legislation made guaranteed issue increasingly inclusive over a period of several years. Effective July 1, 1994, an AHP was required to make a basic health benefits plan available to employers of from 25 to 40 employees who had been without coverage for at least 90 days. Effective July 1, 1996, an AHP was required to make the basic health

benefits plan available to employers of from 3 to 40 employees who had been without coverage for at least 90 days.

Under the current legislation, which became effective July 1, 1997, there is no requirement that every AHP offer a "basic health benefits plan".[1] There is a requirement that every AHP offer its "health benefits plan" which is defined as "a hospital and medical service corporation policy or certificate, a health care services corporation contract, a multiple employer welfare arrangement or any other arrangement under which health services or health benefits are provided to two or more individuals." ARS 20-2301(A)(11). This legislation also revised the definition of "small employer" to include any employer with from 2 but not more than 50 eligible employees. ARS § 20-2301(A)(22). All small employers, not just those that have been without coverage for at least 90 days, became entitled to guaranteed issue. ARS §20-2304(A) and (B).

In addition, the law now requires any AHP to provide a health benefits plan, without regard to health status-related factors, to any small employer who agrees to make the required premium payments. ARS § 20-2304(A). In effect, any AHP that wants to be in the medium or large market must also be in the small market. This provision is broader than federal law and does not exist in most other states (see Exhibit E). It appears that this provision keeps insurers in the small group market that otherwise would have withdrawn.[2]

AHP Reforms

- Guaranteed availability for all small employers. "Small employer" means an employer with two to fifty eligible employees.
- Small employer rates contained within a band.
- Insurers offering health care insurance to medium and large employers must also offer it to small employers

These laws conformed to federal guaranteed availability requirements established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a result, a group health insurer that does not provide guaranteed issue of a group health insurance plan to a small employer is in violation of both Arizona and Federal law. Thus, the issues noted

[1] The Department frequently receives inquiries about what is included in the "basic health benefits plan" that every insurer must offer. Currently, there is no single definition in statute or rule of a basic health benefits plan that every insurer must offer. There are three sets of benefits required by Arizona law in various contexts.

1. All AHPs must offer the statutory mandates found throughout Title 20, applying to hospital and medical service corporations, health care services organizations and all disability health insurers. See Exhibit A.
2. AHPs that are HMOs must also offer basic health care services. A Department rule, AAC R20-6-1906, recently adopted on a temporary basis from previous DHS rules, defines basic health services. These overlap to some extent with the statutory mandates.
3. AHPs that are reinsuring carriers in the Small Employer Reinsurance Program must provide and be reinsured for a certain set of benefits described as a "basic health benefits plan". ARS 20-2349(A)(1). A copy of this set of benefits is available on the Department's website at www.state.az.us/id.

[2] The continuing concern about the availability and affordability of health care insurance is reflected in a variety of legislative initiatives. These include a high risk pool bill proposed in 2001 as House Bill 2589, and the activities of the Statewide Health Care Insurance Plan Task Force, organized in 2000 under House Bill 2050. The House Bill 2050 Task Force received guidance on strategy, coverage issues and coverage options from a Technical Advisory Committee organized by AHCCCS. The committee is comprised of representatives from the physician and hospital community, health insurers, AHCCCS leadership, the Director of Insurance and members of the HB 2050 Task Force itself.

in this report non-compliance with Arizona's AHP laws generally also apply to HIPAA non-compliance.

Premium Tax Exemption

Another aspect of small employer market reform, which became effective July 1, 1996, was the grant of a premium tax exemption. AHPs, like all insurers, must pay a two-percent tax on their premiums. ARS §§ 20-224(B), 20-1060(A). AHPs that break out small group premiums in their annual premium filings with the Department are exempt from that tax for the reported small group premiums. ARS §20-2304(J). Some AHPs have determined that the tax savings would not be worth the administrative cost of breaking out the small employer premiums and do not claim the exemption. The Department's data on small group laws in other states suggests that this is an unusual law.

According to the Department's unaudited calculations, between July 1, 1996, when the exemption went into effect, and December 31, 2000, the exemption resulted in approximately $28,498,000 premium tax savings for the plans that have claimed the exemption. The same calculations show that the premium tax savings in 2000 alone were approximately $9,216,920.

The Department has no precise way to determine the impact of the premium tax exemption on rates or on plan availability. It is possible, however, that if the exemption were eliminated, insurers would add two percent to their small group rates to compensate for the elimination.

STATE OF THE SMALL EMPLOYER MARKET

To assess the state of the market for this report, the Department conducted an informal survey of groups that represent the interests of small business employers to find out the experiences of their members or clients in the small group health insurance market.[3] The survey responses, summarized in Exhibit B, indicate that despite the complex overlay of federal and state laws described above, small employers still experience limited access to group health insurance for reasons of both availability and affordability. The ongoing impediments to availability can be summarized as administrative factors, product limitations, compliance issues and a rapidly shrinking number of AHPs. Small employers uniformly describe affordability as the biggest access issue. They generally perceive employee health status, prescription drugs, statutory mandates and lack of competition to be the primary affordability problems.

Reasons health care insurance is unavailable: *

1. Administrative factors
2. Lack of competition
3. Product limitations
4. Compliance issues

Reasons health care insurance is unaffordable: *

1. Employee health status
2. Prescription drugs
3. Statutory mandates
4. Lack of competition

*As reported by small employers

[3] The Department requested information from the National Federation of Independent Business, the Arizona Association of Health Underwriters, Health Care Group, and SIBA Consultants.

Availability Issues

Administrative factors

Small employers identified the following practical, administrative reasons that they do not or cannot obtain the insurance that is available in their market.

- Small business owners and managers do not know what AHPs or products are available in particular geographic areas.
- Small business owners or managers need education about how to work effectively with brokers and producers.
- The application process is complex, time consuming and frustrating, for owners and employees. This is particularly true when a small employer goes all the way through the process, does not get a satisfactory quote and then has to start the process over with another AHP.
- The price often changes dramatically between the initial estimate, which appears affordable, and the final quotation, which does not. This discrepancy is usually the result of a change in the numbers of employees who decide to participate and the final information regarding health status of employees.
- Small business owners or managers do not have resources or training to understand or administer benefit plans. Once the coverage is in place, the paperwork can be overwhelming.
    - The coverage and contracts change frequently – employers and employees feel as if they are always on the benefits learning curve.
    - Coverage is not meaningful in some rural areas where people have to travel a long distance to see a provider in their network, or to see any provider at all.
    - Cost sharing with the employee is a major issue – employers are shifting more cost to enrollees, through higher percentages of the premiums, higher copays and higher deductibles. This causes dissatisfaction and undermines the "benefit" aspect of healthcare insurance. It also drives down enrollment, which in turn drives up price.

Product Limitations

To comply with the AHP laws, an AHP must offer "at least one health benefits plan" to small employers. ARS § 20-2304(A). The range of products in the market includes HMOs, PPOs and Point of Service plans. If the AHP offers more than one health benefits plan to small employers, it must offer all such plans to all small employers that apply. ARS § 20-2304(B).

Of course, what product is available depends on the AHP to which the small employer applies. Having more than one AHP or more than one product in the marketplace does not translate to much choice on an employer by employer basis. Many small employers report they have few options. For example, the HMO choice is very limited in rural areas. The PPO choice also is diminishing as AHPs find it harder to maintain rural networks or leave the entire group market for other reasons.

Some AHPs are willing to offer limited packages to increase affordability to small employers. Others are not, because benefit variations complicate plan administration.

Small employers appear to be increasingly interested in products outside the conventional benefit plan, such as medical savings accounts. They also express increasing interest in products outside the realm of insurance, such as discount cards.

Compliance issues

Many small employers have a perception that (i) some AHPs do not comply with the small group laws, and (ii) some of those in compliance try to find legal ways to avoid dealing with small employers. The Department's AHP enforcement activities can be generally categorized as follows:

Carrying Out Market Conduct Examinations

Market conduct examinations are a very effective avenue for enforcement in this area. Since May 2000, the Department has issued 18 orders relating to the state law versions of HIPAA requirements for large group, small group or individual coverage. These are summarized in Exhibit C ("Orders Citing HIPAA Violations"). In connection with these orders, the Department has imposed fines totaling $588,500.

Reviewing Definition of "Eligible Employee"

The Department has issued several orders and levied fines on certain AHPs for substituting their own definition of "eligible employees" for that of the employer in deciding whether the business qualifies as a small group. See Exhibit C. This practice can affect whether a group qualifies as a "small employer" under ARS § 20-2301(A)(22) and thus whether the group is entitled to guaranteed issuance.

Assessing Small Group Disincentives

In recent months, the Department has received complaints that some AHPs employ various small group "disincentives". The allegations, which come from producers and brokers or insurers, not from consumers, appear to fall into three categories:

1. That AHPs reduce or eliminate commissions for brokers and producers who deal with small groups;
2. That AHPs create administrative barriers to coverage such as requiring that agents or producers seeking quotes for small groups request them from home offices in other states, while quotes for middle and small sized groups are more easily obtained locally; and
3. That AHPs decline to quote on coverage for small groups on the grounds that the insurance company knows its quote will not be competitive.

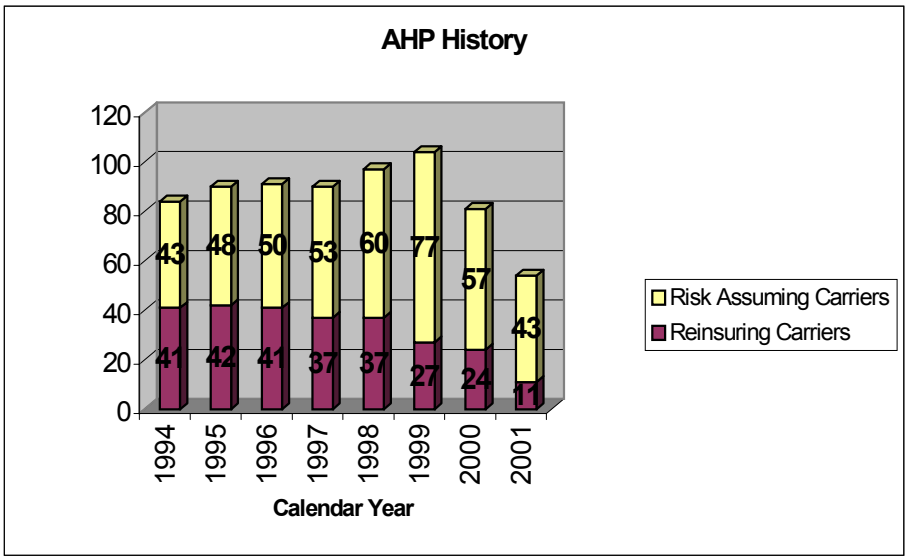
With regard to commission structures, there is no federal or state law that specifically prohibits an AHP from modifying its commission arrangements where HIPAA eligible individuals or small groups are concerned. The Department addressed the commission issue in Circular Letter 1998-10, attached as part of Exhibit D, and determined that the ability to take enforcement action depends on being able to establish that the commission schedule is intended to discourage marketing to small groups. This does not necessarily prohibit a commission schedule that has a reasonable business justification (such as lowering administrative costs or having a competitive commission schedule) and also has the secondary effect of discouraging small group business.

The Department investigates complaints about commission schedules to determine if AHPs are intentionally discouraging producers from marketing to small groups. The Department will take appropriate action if the requisite intent can be established.

With regard to the allegations (i) that AHPs create administrative barriers to obtaining coverage, and (ii) that AHPs decline to provide quotes because they would not be competitive, the Department continues to investigate complaints and alleged violations and to take disciplinary action as appropriate. Nothing in the AHP laws create an exception to the guaranteed issue requirements for insurers that set their rates outside the competitive range but within the allowable rating band. It is the AHP's responsibility to make coverage available and quote a rate that is calculated in accordance with the law. The employer to whom the coverage is quoted can assess competitiveness and affordability.

Shrinkage in the Market and Lack of Competition

Another issue that adversely affects availability of group health insurance to small employers is the number of AHPs marketing group insurance in Arizona to any groups – small, medium or large. The Department's records indicate that that the number of AHPs peaked towards the end of 1999 at 104. Since that time the number has steadily declined to the present total of 54 as of December 31, 2001. That represents a loss of approximately one-half of the AHPs in only two years.



Although all AHPs must offer at least one health benefits plan to small employers, not all 54 AHPs are necessarily active in the small group market. At any given point there may be some that do not have small group business for legitimate reasons. As of December 31, 2000 there were at least 27 that were active in the small group market, i.e., 27 AHPs that claimed the premium tax exemption for 2000. There probably are others active in the market that did not claim the exemption.

Premium tax exemption records show that among the AHPs claiming the exemption, there is a marked concentration of premium in certain AHPs. Five AHPs reported just over 70% of the small group premium. Three of these were health care services organizations (HMOs). One was a hospital, medical, dental and optometric service corporation (HMO and non-HMO products). The fifth was a disability insurance

Market Share among 27 AHPs*

AHP	Product	Percentage
1	HMO	27.25%
2	HMO/Non-HMO	20.10
3	HMO	8.65
4	HMO	7.20
5	Non-HMO	7.05
		70.25
7 - 22	Non-HMO	29.27%
		100%

*These 27 AHPs claimed the premium tax exemption in 2000

company. Among the remaining 22 AHPs, which collectively reported just under 30% of the small group premium, not one offered an HMO product and not one reported more than 4.5% of the total premium reported. Presumably, these 22 AHPs are not competitive with regard to key factors such as price or benefit plans. These percentages tend to validate the perception among small employers that there are few health care insurance companies to work with.

The Department's data on small group markets in other states indicates that a shrinking market is common. See Exhibit E. Of fourteen states that responded to the Department's inquiries, three reported that they have thirteen or fewer insurers in the small group market. Of those three, one has only two insurers. This suggests that how to encourage small employers to buy health care coverage for their employees needs to be looked at in tandem with how to get insurers to stay in the market and actively market to small employers.

Title 20 contains two provisions that could enhance availability even in a shrinking market by allowing small employers to pool their risk and premiums to obtain coverage. In theory, such provisions should attract insurers and spark competition. As a practical matter, however, these statutes have not proved effective.

First, the disability insurance laws specify that group disability insurance includes a policy issued to an "association, which shall have a constitution and bylaws and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five members." ARS § 20-1401(A)(2). This law applies to associations formed in Arizona[4], a number of which were active over the last 10 to 15 years, but few of which prospered. Groups that represent the interests of small employers suggest that associations generally failed to attract enough membership to survive, for the following reasons:

- Many associations have not met the requirement of a common purpose other than wanting to get health care insurance.
- Businesses have not wanted to take on responsibility for administration of the plan, which may be required to keep costs down.
- The early associations that formed tended to have unhealthy members, and insurers have become wary of the underwriting problems.
- Many associations have not been able to find insurers to offer them an affordable product.
- Insurers sometimes underwrite each employer group in the association separately. As a result, the association members do not get the financial benefit of being under-written as a bigger group.

[4] Some Arizona residents currently are covered by associations formed in other states.

Second, the AHP law provides: "[A]n accountable health plan may market health benefit plans to groups of small employers from the same or different industries that elect to pool their risk on a voluntary basis." ARS § 20-2313(C). The Department is not aware of any pools formed pursuant to this law. The small employer representatives the Department surveyed suggested that the statute was not used because (i) it is not well known, and (ii) pools are likely to share some of the problems associations have encountered in building the critical membership mass and finding insurers that will offer affordable coverage. This concern is supported by the experience reported in other states with a similar structure, i.e., the healthcare purchasing cooperative. See the discussion on page 12.

Affordability Issues

Pricing Factors

Poor availability by itself has an impact on affordability. The decline in the number of AHPs reduces competition and results in higher rates, especially for small groups, in which the risk cannot be spread over a large number of employees.

Small employers perceive several factors that make health insurance unaffordable:

- Medical underwriting of employees with health problems.
- The rising cost of prescription drugs
- Statutory mandates that cannot be excluded from coverage. Small employers often perceive these to add cost and bring no value.
- Lack of competition among insurers.

AHP Rates

- AHP laws set a rating band for small group rates.
- AHPs do not file group rates with the Department.
- AHPs annually file an actuary's certificate stating:
  - The AHP's rates were calculated in accordance with the law, and
  - The AHP's rates are actuarially sound.

Rate-Setting

The AHP laws have rate-setting and rate-renewal provisions that establish a rating band for small group coverage. The rating bands are designed to keep premiums affordable. The laws have a complicated technical structure.[5] The Department gets many inquiries from AHPs trying to interpret these statutes. This ambiguity appears to undermine uniformity in the rate-setting process and to create leeway to (i) produce rates that, although legal, are unaffordable to many small employers, and (ii) increase

[5] With regard to setting rates, A.R.S. §20-2311(A) states: "The premium rate that an accountable health plan charges during a rating period for a health benefits plan issued to a small employer shall not vary by more than sixty per cent from the index rate for health benefits plans involving the same or similar coverage, family size and composition, and geographic area."

A.R.S. §20- 2301(A)(14) defines "index rate" as "the arithmetic average of the applicable base premium rate and the highest premium rate that could have been charged under a rating system by the accountable health plan to small employers for a health benefits plan involving the same or similar coverage, family size and composition, and geographic area."

A.R.S §20-2301(A)(3) defines "base premium rate" as "the lowest premium rate that could have been charged under a rating system by the accountable health plan to small employers for health benefits plans involving the same or similar coverage, family size and composition, and geographic area."

With regard to renewal ratings, A.R.S. §20-2311(C) states: "The percentage increase in the premium rate that is charged to a small employer for a new rating period may not exceed the sum of the following: (1) The percentage change in the base premium rate. (2) Fifteen percentage points. (3) Any adjustment due to a change in coverage, family size or composition, geographic area or demographic characteristics."

rates substantially through changes to the base premium rate which is itself largely unregulated. The rating band itself does not have the effect of restricting rates.

Under ARS §20-2311(E), AHPs do not file their small group rates with the Department. Instead, they file a statement prepared by an actuary, certifying that the rates comply with the law and that the rating methods are actuarially sound. The calculations necessary to provide the actuarial certificate are complex and take considerable actuarial knowledge to evaluate, with regard both to the actuary's calculations and to the content of the certificate and the insurer's data, upon which the calculations and content were based. The fact that insurers or actuaries apparently employ varying interpretations of the law adds to the complication. Varying interpretations are not necessarily synonymous with non-compliance but they make compliance very difficult to determine.

The Department's enforcement activity in the area of rate setting has centered on making sure that all AHP's file the required certificates. The Department is in the process of enhancing its compliance efforts in this area with the following steps:

- Reviewing certificates filed for 2001 on a targeted basis.
- Surveying other states to determine if any AHPs filing in Arizona have had problems with similar filings in other states. Those that have had problems may be among the companies with certificates targeted for review in Arizona.
- Reviewing the criteria for examinations in this area and for the qualifications of our examiners in order to ensure we have examiners who are qualified to determine compliance in this highly technical area.
- Surveying other states to learn which, if any, are working on reforms to their rate setting-requirements.

EFFECT OF SIMILAR REFORMS IN OTHER STATES

With the assistance of the National Association of Insurance Commissioners, the Department contacted all other states to ask if they had the following:

1. A law that requires group health insurers to offer at least one plan to small employers on a guaranteed issue basis if they offer plans to medium or large employers.
2. A small employers reinsurance program open to all group health insurers.
3. An exemption from taxes on small employers' group health insurance premiums.
4. Specific notice requirements for termination of small group coverage.

A table prepared as Exhibit E contains the results of the survey for those states responding to our request for this information. While only 18 states responded to the survey, the responses provide some valuable information. For example:

Arizona has two requirements which none of the responding states have:

- The law requiring group health insurers to market to small employers as a condition of doing business in this state.
- The premium tax exemption for small group health insurance premiums. Other states are considering exemptions.

Other states have at least two significant problems in common with Arizona:

- A significant reduction in the number of group health insurers.
- Poor participation in state sponsored reinsurance pools.

Various states have unusual provisions of their own:

- One state subjects all small group insurers to reinsurance program assessments, so all have elected to be reinsuring carriers.
- One state gives a refundable tax credit to employers that provide coverage for their employees for five years.

The Department also asked the other states if any of the reforms enacted had the effect of keeping insurers in the small group market if those insurers would otherwise have left. None of the responding states indicated that they had. It appears that no state has found a formula for preventing a significant number of insurers from withdrawing from the group health insurance market.

OTHER MODELS

High Risk Pools

In recent years, the legislature has considered several bills to create a market of last resort for health insurance (i.e., a high-risk pool) in Arizona. The Technical Advisory Committee to the HB2050 Task Force worked on recommendations regarding high-risk pools as well. There are a number of factors generally recognized as critical to a successful high-risk pool:[6]

1. A premium cap rate, to assure reasonable affordability.
2. Permanent, adequate funding to supplement premiums that participants pay. The cost of providing health care services to high-risk enrollees exceeds the cost on the commercial market and cannot be covered by premiums alone, even though high-risk pool premiums are typically higher than premiums in the commercial market.
3. Sound actuarial analysis.
4. Appropriate eligibility requirements, including an enrollment cap, to assure the pool's function as a market of last resort
5. Resources for oversight in the designated state agency.
6. Other aspects of the program structure, including benefit design, types of plans, and details of program financing (premium rates, sources of subsidies, etc.).

Components of Sound Risk Pools

- Adequate subsidized funding
- Premium caps
- Clear eligibility requirements
- An enrollment cap
- Adequate resources for oversight
- Appropriate program structure

It is hard to assess the likely impact of a high risk pool on the small group market. A well-structured high-risk pool can solve the availability problem for high-risk people who can afford the coverage. Many of these people may be owners or employees of small businesses or be self-employed. Congregating them, and their medical claims

[6] Every year, Communicating for Agriculture publishes a state-by-state analysis of risk pools across the country called *Comprehensive Health Insurance for High Risk individuals*. The discussion of risk pools above is drawn in part from the 2001-2002 edition. The publication is available from Communicating for Agriculture at 218-739-3241 or www.selfemployedcountry.org.

expenses, in a separate pool should help to keep costs and premiums down in other sectors of the market. That could in turn make the market more appealing to AHPs.

On the other hand, a high risk pool does not make insurance available or affordable for the less-high risk, and less affluent, uninsured, many of whom are also owners or employees of small businesses or self-employed. This will be a problem in particular for people with serious or chronic health problems who cannot afford coverage in the commercial market but who are not sick enough to qualify for high-risk pool enrollment or are excluded by an enrollment cap. Unless there is some method developed to subsidize payment of the high premiums for this group of people, they will continue to be uninsured because the available insurance is unaffordable.

Healthcare Purchasing Cooperatives

Healthcare Purchasing Cooperatives (HPCs) have been created in some states as a possible solution to the problem of increasing the availability and affordability of health care insurance for small employers. The Department has reviewed two comprehensive analyses of the pros and cons of HPCs and their track records in states where they have been implemented. [7]

While HPCs can be broadly defined, they differ from other pooling mechanisms in at least three respects:

1. An HPC has a minimum of two health insurers participating[8];
2. Each individual participant in the HPC has a choice of insurers; and
3. HPCs do not impose any membership criteria other than group size. They do not restrict membership to certain trades, professions or business associations.

The literature indicates that HPCs have not made much of a dent on the number of uninsured in or out of the small group market for several reasons:

- Guaranteed issue laws and other contemporaneous health care reforms have undermined the effectiveness of the HPC. Health insurers do not get much additional business through an HPC. If anything, insurers perceive that HPCs will cost them business, because they have to share business inside the HPC that they otherwise would be able to market for directly.
- HPCs have not resulted in lower prices for purchasers and consumers, because of at least three factors:
    - HPCs have not achieved administrative savings. Enrollment has been too low to result in economies of scale and increased competition in the small group market has required participating plans to trim administrative costs even before joining HPCs.
    - HPC supporters assumed that HPCs could grow without relying on agents and brokers, thus eliminating commissions. Agents and brokers have turned out to be critical to building membership in HPCs.

[7] Sources: Brandel and Pfannerstill (Milliman USA), AHCCCS Issue Paper on Purchasing Pools, July 30, 2001; Wicks and Hall, Purchasing Cooperatives for Small Employees: Performance and Prospects, The Millbank Quarterly, Vol. 78, No. 4, 2000.

[8] Arizona law contains a broad grant of authority to form a purchasing pool that could encompass any health benefit plan in place between one, and not necessarily more than one, AHP and the purchasing pool. See ARS § 20-2313(C), which provides: "[A] n accountable health plan may market health benefits plans to groups of small employers from the same or different industries that elect to pool their risks on a voluntary basis." It is not clear that this statute by itself authorizes the formation of HPCs in Arizona.

    - HPCs have had adverse selection problems, especially those that offer some choice among types of coverage (HMO, PPO, POS, etc.)
- Because prices are not lower and enrollment has not burgeoned, HPCs have not resulted in increased negotiation power on behalf of small businesses. This in turn keeps prices high.
- HPCs are recognized favorably for increasing employee choice. Generally this means there is more choice among health insurers but not necessarily among products or types of coverage. As noted above, HPCs with a range of products have been more likely to experience adverse selection.

These problems generally result from low enrollment in HPCs -- the same problem that plagued the health insurance associations formed in Arizona under ARS § 20-1401(A)(2). See discussion on page 8.

ISSUES OF POSSIBLE FEDERAL PRE-EMPTION

Implications for Health Insurance in Arizona

Issues of federal preemption arise with regard to the impact of proposed federal legislation on Arizona's ability to enforce state laws that protect Arizona health insurance consumers. These issues encompass but are not limited to small group health insurance. For example, the Patient Bill of Rights (PBOR) legislation considered by Congress in 2001 raised several federal preemption questions.

Preserving state appeals processes.
Arizona has had a health care appeals process in place since July of 1998. Each year, Arizona's legislature has enacted amendments to improve the process and tailor it to unique needs of Arizona's citizens and its health insurance market. State policymakers should be concerned about federal legislation in this area that does not expressly preserve the effective state processes that already permit consumers to challenge their health insurer's coverage decisions.

Preserving state patient protection laws.
Arizona already has laws establishing many of the substantive protections embodied in PBOR proposals under consideration in the House.[9] The content of these measures is the product of negotiation and compromise among affected Arizona stakeholders. Arizona consumers could be prejudiced by federal PBOR legislation that takes a "one-size-fits-all" approach and preempts state laws that are as protective or more protective than federal minimum standards.

[9] In the 2000 legislative session, Arizona enacted two comprehensive pieces of legislation to more effectively regulate the health insurance market and to protect Arizona's health insurance consumers. These were HB 2600, the Managed Care Accountability Act and SB 1330 relating to healthcare plans oversight. These bills, together with earlier legislation, include the following patient protections: prohibition on physician "gag" clauses; obligatory comprehensive disclosure statements to the insured; the ability for an insured to obtain non-formulary drugs; and mandated coverage of cancer clinical trials, off-label use of prescription drugs to treat cancer; and continuity of care for pregnant women and patients with terminal conditions.

Preserving local enforcement of patient protections.
Federal PBOR legislation will have little practical benefit unless Congress commits federal resources for enforcement. The only insurance regulatory infrastructure in this country exists at the state level. Arizona consumers could be prejudiced if Congress preempts, rather than uses, the existing state infrastructure and expertise for enforcement and consumer assistance.

Preserving states ability to handle consumer complaints.
Some federal proposals would afford consumers broader access to federal courts and remedies to enforce their policies. As indicated above, however, states have extensive administrative enforcement mechanisms in place and can efficiently and expeditiously pursue administrative remedies on behalf of consumers in many cases. Arizona consumers could be prejudiced if the federal courts were to become the exclusive means for enforcement of patients' rights.

Association Health Plans

One aspect of proposed federal legislation that could pose a threat to the small group health insurance market in Arizona is the Association Health Plan. The Association Health Plan provisions included in the PBOR passed by the House of Representatives in 2001 had a key requirement in common with the "associations" allowed under Arizona law at ARS § 20-1401(A)(2), i.e. that the associations have a bona fide purpose other than obtaining insurance. Association Health Plans created under the PBOR could purchase coverage from an insurer or be self-insured. They would bypass state regulation in areas such as state consumer protections, solvency requirements, and mandated benefits.

Exemptions from state law for Association Health Plans could counter the progress Arizona has made through small group market reform, which has increased the number of people covered in the small group insurance market place. Because state consumer protection laws would not bind Association Health Plans, similarly situated employees could have different levels of protection, with the Association Health Plan consumers at increased risk for fraud and abuse.

In addition, because Association Health Plans would not be required to provide state-mandated benefits under all their coverage options, they would be able craft their marketing and benefits to limit access by the sickest individuals. If small groups participating in Association Health Plans had members who became too sick to remain in less expensive Association Health Plans alternatives, the small groups would be able to to reenter the state-based small group market through the guarantee issue requirements. These two factors could cause adverse selection in the state-based small group market.

Finally, according to the Congressional Budget Office (CBO), Association Health Plans do not appear to effectively address the fundamental problem of affordability of insurance. A CBO report issued in 2,000 ("Increasing Small Firm Health Insurance Through Association Health Plans and HealthMarts") found that 80 percent of small employers would see their premiums increase if Association Health Plans were exempted from state insurance reforms. Moreover, the CBO found that this legislation would do little

for the uninsured – nationwide only 330,000 of the 42.5 million uninsured Americans would gain coverage through Association Health Plans.

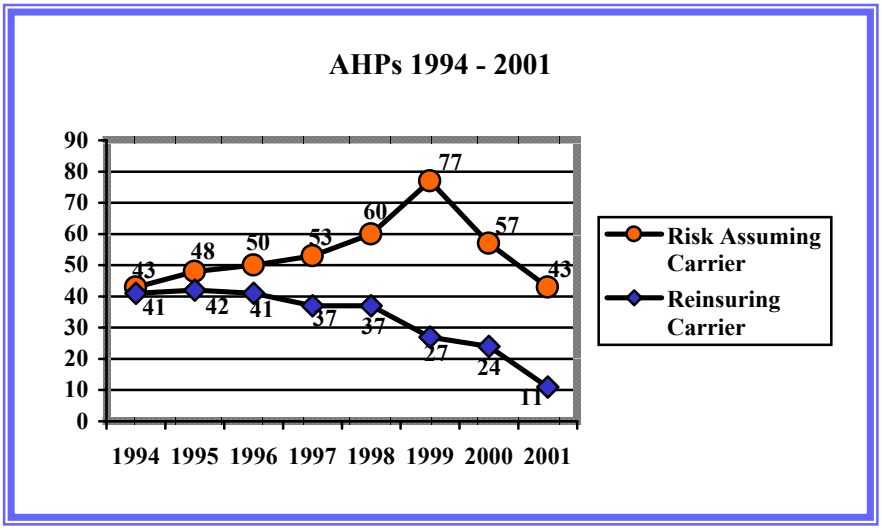
SMALL EMPLOYER REINSURANCE PROGRAM

The Small Employer Reinsurance Program (SERP) was created in 1993 (A.R.S. §20-2341 et seq.) as part of Arizona's legislative reform of the small group health insurance market. As discussed above, as a result of the reforms, insurers doing business in the small group market must guarantee issuance of coverage to all small groups.

All AHPs must elect to be either a reinsuring carrier or risk-assuming carrier. Risk-assuming carriers assume the full risk for their small group enrollees and do not participate in SERP, fiscally or otherwise.[10] Reinsuring carriers may reinsure their small group lives in SERP. Reinsuring carriers are assessed for the losses of the program and for administrative costs and they share in any claims savings resulting from the reinsurance arrangement.

SERP has not flourished.

- Participation has been low since the program began. As of December 31, 2001, there are 54 AHPs. Of these, only 11 (20%) have elected to be reinsuring carriers through SERP. Of the 11 reinsuring carriers, only three have ceded any lives to the Program and the total number of lives ceded is only 17. It appears that the remaining 8 reinsuring carriers do not need the program, either because they accept full risk, despite identifying themselves as reinsuring carriers, or because they can obtain reinsurance elsewhere.



- While the number of risk-assuming AHPs grew at one point, the number of reinsuring AHPs has declined steadily.

- Although program participation is minimal, program expenses are not. The department's unaudited calculation shows that claims administration, audit and other fees have averaged $31,343.49 per year since the first program year in 1994. These fees were approximately $40,698 for the fiscal year that ended June 30, 2001. Reinsuring carriers have paid assessments totaling $336,513 since SERP was established in 1993. See the table on page 16. The most recent assessment was in March 2000, in the amount of $5,385 for each of the 24

[10] Although they do not participate in SERP, risk-assuming carriers may elect to obtain reinsurance in the private market.

Small Employers Reinsurance Program
Adminstrative Fund Summary

Fiscal Year Ended	Beginning Balance	Assessments Collected	Expenses	Ending Balance
6/30/1994	0	53,650.00	270.40	53,379.60
6/30/1995	53,379.60	11,600.00	48,555.73	16,423.87
6/30/1996	16,423.87	52,402.00	27,013.25	41,812.62
6/30/1997	41,812.62	0	32,438.96	9,373.66
6/30/1998	9,373.66	58,421.15	39,694.05	28,100.76
6/30/1999	28,100.76	31,200.00	26,963.77	32,336.99
6/30/2000	32,336.99	123,855.00	34,634.10	121,557.89
6/30/2001	121,557.89	5,385.00	16,802.23	110,140.66
Inception to 6/30/01	**0**	**336,513.15**	**226,372.49**	**110,140.66**

The total expense does not include $24,375.50 in administrator fees paid out of the administrator's cash account for the fiscal year ended June 30, 2001. Total expenses for the year were $40,698.

reinsuring carriers, for a total of $129,240. Although the number of reinsuring carriers may continue to decline, SERP administrative expenses will likely remain fairly constant, necessitating higher assessments for each reinsuring carrier.

- The AHP laws require that a nine-member board oversee SERP. ARS § 20-2343(A). It has been difficult for the Department to attract and retain Board members. At present there are only five Board members out of the nine prescribed by law. Some of the vacancies have existed for over two years and currently there are no candidates for the empty Board seats. Because a quorum must be determined based on the nine required Board members, all five existing Board members must be present at Board meetings in order for there to be a quorum and for the Board to conduct business. This often leads to Board meetings being cancelled and re-scheduled.

- The Department has found it difficult to obtain bids for the required administrative services for such a small program. The present claim administrator, located in Connecticut, was the only administrator to bid in 1999 and has been renewed each year since. When an RFP was distributed for an audit of the plan year ended June 30, 2000, nobody submitted a bid. Several accounting firms told the Procurement Office that the work and fee were too small for the firms to respond to the RFP. Eventually, one quotation was received and accepted after a subsequent Request for Quotation was sent out.

The bar graph on page 8 shows that a higher proportion of reinsuring carriers have left the market than have risk assuming. That fact, coupled with the small number of lives

ceded by a total of three AHPs, suggests that SERP has little value to most AHPs and does not motivate them to remain in the market. State policymakers should consider whether the low SERP participation, Board vacancies, costs and assessments, difficulty in procuring required administrative services and disproportionate program management expenses outweigh the benefits of providing reinsurance to only three insurers. For this reason the Department's 2002 legislative agenda currently includes the repeal of A.R.S. §20-2341 et seq. and SERP. SERP's Plan of Operation allows for an orderly termination of the Program.

As an alternative to termination, SERP could be reformed. For example, in Arizona, SERP assessments are levied only on those AHPs that have identified themselves as reinsuring carriers. In Idaho, all small group carriers are assessed, whether or not they are reinsuring carriers. As a result, all of them have elected to be reinsuring carriers.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Arizona's AHP laws have been in place for eight years. Guaranteed issue requirements, along with the requirement that any AHP that wants to be in the medium or large market must also be in the small market have increased and protected availability.

Availability is significantly undermined, however, by diminishing affordability. Price remains the greatest obstacle to coverage. The limited laws directed at controlling rates do not appear to have been effective and are difficult to administer. The premium tax exemption does not appear to have a significant impact on the affordability of coverage for small groups.

Even when insurance is affordable, small employers find that a variety of practical factors, such as administrative problems, the lack of competition in a shrinking market, product limitations and compliance issues interfere with obtaining coverage.

There are many health care coverage models available across the nation and being considered in Arizona. One of these, the high risk pool, has the potential to succeed in covering a very limited number of people, provided it is carefully structured and adequately funded. Other models, such as the healthcare purchasing cooperative, have the much broader purpose of significantly reducing the overall number of uninsured. They have not as a rule succeeded, generally because they do not attract enough of the uninsured population.

Federal preemption looms as a threat to, among other things, Arizona's progress with regard to small group reforms. This is certainly true with regard to Association Health Plans, which could deny Arizona consumers important protections and undermine the economic foundation of the existing small group market.

Finally, the Small Employer Reinsurance Program provides little apparent benefit to consumers or insurers in return for the public resources and industry assessments required to operate it.

Recommendations

1. Arizona small group health insurance consumers would benefit from a legislatively established rate-setting structure that is less subject to interpretation and more

easily enforced.

2. A certain number of high risk Arizona consumers would benefit from a high-risk pool/market of last resort, as long as the pool was properly structured. Proper structure includes:
    - Premium caps
    - Permanent, adequate funding to supplement premiums
    - Sound actuarial analysis
    - Appropriate eligibility requirements
    - Resources for oversight
    - Details of program structure such as benefit design and program financing.

3. Arizona consumers would benefit from a clear legislative determination on the question whether health care insurers are prohibited from using commission and compensation structures and other practices that effectively discourage sales to small employers.

4. Repeal the Small Employer Reinsurance Program or restructure it to enhance participation and simplify administration.

Exhibit A

MANDATED BENEFITS

Health Insurance Benefits Mandated By Arizona Law

Mandate	Group	Individual	HCSO	HMDOSC	Prepaid Dental
Provide immediate coverage for 31 days for newborn children	20-1402(A)(2)	20-1342(A)(3)	20-1057(B)	20-826(E)	20-1007(B)
Provide immediate coverage for 31 days for adopted children or children placed for adoption	20-1402(A)(2)	20-1342(A)(3)	20-1057(B)	20-826(E)	20-1007(B)
Provide continuing coverage for handicapped children when they reach the limiting age for dependent children specified in the policy	20-1407	20-1342.01	N/A	20-826(F)	N/A
Pay benefits for surgical service covered by a policy regardless of the place of service	20-1402(A)(4)(a)	20-1342(A)(8)(a)	20-1051 (included in definition)	20-826(C)(1)	N/A
Pay benefits for home health services prescribed in lieu of hospital services	20-1402(A)(4)(b)	20-1342(A)(8)(b)	20-1051 (included in definition)	20-826(C)(2)	N/A
Pay benefits for diagnostic services performed outside a hospital in lieu of inpatient services which would have been covered	20-1402(A)(4)(c)	20-1342(A)(8)(c)	20-1051 (included in definition)	20-826(C)(3)	N/A
Pay benefits for services performed in hospital's outpatient department or in a freestanding surgical facility, providing such services would have been covered if performed as inpatient services	20-1402(A)(4)(d)	20-1342(A)(8)(d)	20-1051 (included in definition)	20-826(C)(4)	N/A
Provide coverage for breast reconstructive surgery and 2 external postoperative prostheses following a covered mastectomy Expanded 10/21/98 by Women's Health and Cancer Rights Act. Must now also cover reconstructive surgery of the other breast to maintain symmetry, complications of mastectomy including lymphedemas, and no numerical limit on the number of prostheses	20-1402(A)(5)	20-1342(A)(9)	20-1057(I)	20-826(H)	N/A
Provide coverage for mammograms	20-1402(A)(6)	20-1342(A)(10)	20-1057(J)	20-826(I)	N/A
Provide maternity benefits for the natural mother of an adopted child if the policy provides maternity benefits	20-1402(A)(7 & 8) 20-2321(A & B)	20-1342(A)(11 &12)	20-1057(K & L) 20-2321(A & B)	20-826(J & K) 20-2321(A & B)	N/A
Any policy that covers maternity must provide for a minimum 48 hours hospital stay following normal vaginal deliveries and 96 hours following cesarean section deliveries	20-1402(B & C) 20-2321(F)	20-1342(B & C)	20-1057(R & S) 20-2321(F)	20-826(N & O) 20-2321(F)	N/A
Provide diabetes supplies, insulin, syringes, etc. if diabetes is covered by the policy	20-1402(D & E) 20-2325	20-1342(D & E)	20-1057(T & U) 20-2325	20-826(P & Q) 20-2325	N/A

Additional Requirements

Requirement	Group	Individual	HCSO	HMDOSC
Provides that the plan cannot include a lifetime limit on mental health benefits that does not also apply to all other health services (some exceptions)	20-2322 (only applies to employer groups with more than 50 employees)	N/A	20-2322 (only applies to employer groups with more than 50 employees)	20-2322 (only applies to employer groups with more than 50 employees)
Provide conversion coverage for those who lose eligibility	20-1408	20-1377	20-1057(M, N, & O), 20-1408	20-1408
Pre-existing conditions crediting for prior creditable coverage	20-2310	20-1379(Only for eligible individuals)	20-2310(Group), 20-1379 (Only for eligible individuals)	20-2310 (Group), 20-1379 (Only for eligible individuals)
Guaranteed issuance of coverage	20-2304 (Groups of 2-50)	20-1379 (Only for eligible individuals)	20-2304 (Groups of 2-50), 20-1379 (Only for eligible individuals)	20-2304 (Groups of 2-50), 20-1379 (Only for eligible individuals)
If plan covers prescription drugs, must cover off-label use drugs for cancer treatment (effective 1/1/2001)	20-1402(F & G) 20-2326	20-1342(F & G)	20-1057(V & W)	20-826(R & S)
If plan covers prescription drugs, must have process for receiving medically necessary non-formulary drugs and a process for receiving medically necessary formulary and non-formulary drugs during non-business hours (effective 1/1/2001)	N/A	N/A	20-1057.02(B)	20-841.05(B)
If plan covers prescription drugs, must allow benefits for at least 60 days after notice of plan's removal of a drug from the formulary (effective 1/1/2001)	N/A	N/A	20-1057(E)	20-841.05(E)
Continuity of care for ongoing treatment (effective 1/1/2001)	N/A	N/A	20-1057.04	20-841.06
Standing referrals (effective 1/1/2001)	N/A	N/A	20-1057.01	20-841.04
Medical supplies vendors must be readily accessible (effective 1/1/2001)	N/A	N/A	20-1057.05	20-841.07
Chiropractic Care (effective 1/1/2001 for HCSO's)	20-1406.01	20-1376.01	20-1057.03 12 visit minimum/year	20-841.01

Additional Requirements (Continued)

Requirement	Group	Individual	HCSO	HMDOSC
Must cover emergency room initial medical screening and stabilization without prior authorization. Emergency ambulance services must also be covered starting 7/18/2000	20-2803	20-2803	20-2803	20-2803
If plan covers prescription drugs, must cover medical foods used to treat inherited metabolic disorders (effective 7/18/2000)	20-1402 20-2326	20-1342	20-1057	20-826
Insurers must pay "covered patient costs" for insureds who participate in cancer clinical trials at an Arizona institution (effective 1/1/2001)	20-1402.01	20-1342.03	20-1057.01 20-2326	20-826.01

If a policy provides coverage for psychiatric, drug abuse or alcoholism services, reimbursement for such services shall be made in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital. This applies to the following policies:

- Group: §20-1406(C)
- Individual: §20-1376(C)
- HMDOSC: §20-841(C)
- HCSO: §20-1057(C)

If a policy provides for or offers reimbursement for a service within the lawful scope of practice of a registered nurse practitioner or a certified registered nurse qualified under the rules adopted by the State Board of Nursing regarding extended nursing practice and licensed pursuant to Title 32, Chapter 15, benefits shall not be denied to a subscriber receiving such a service. Reimbursement for the cost of the service may be made directly to the person licensed pursuant to Title 32, Chapter 15 (A.R.S. §32-1601 *et seq*.) or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution. This applies to the following policies:

- Group: §20-1406.03
- Individual: §20-1376.03
- HMDOSC: §20-841.03

(This does not apply to HCSO's)

"Group" = Group Health Insurance "Individual" = Individual Health Insurance "HCSO" = Health Care Services Organization (HMO)
"HMDOSC" = Hospital, Medical, Dental and Optometric Service Corporation Revised 5/2000

Exhibit B

SURVEY OF ENTITIES REPRESENTING

SMALL GROUP INTERESTS

Question	Summary of responses
Has health care become relatively more or less available since 1993?	Less available.
Has health care become relatively more or less affordable since 1993?	Less affordable.
What are the factors that drive price up?	• Prescription drug coverage • Mandates • Employees with health problems • Lack of competition among insurers.
Aside from price, what, if any, are the perceived barriers to buying the insurance that is available?	• Small business owners or managers do not have resources or training to understand or administer benefit plans. Once the coverage is in place, the paperwork is overwhelming. • Small business owners and managers do not know what is available in terms of what carriers, products and geographical limitations on coverage. • There are fewer carriers in the market • Small business owners and managers need education about how to work effectively with brokers and producers. • The application process is complex, time consuming and frustrating. • The price often changes dramatically between the initial estimate and the final quotation, usually because of the number of employees who decide to participate and the health status of those employees. • The coverage and contracts change frequently – employers and employees feel as if they are always on the benefits learning curve. • Coverage is not meaningful in rural areas where there are not providers. • Cost sharing with the employee is a major issue – employers are shifting more cost to enrollees, through higher percentages of the premiums, higher copays and higher deductibles. That drives down enrollment, which in turn drives up price. • It is not possible to take price out of the equation
What types of products and benefit packages are available to small groups?	• The range of products still includes HMOs, PPOs and POSs. The HMO choice is very limited in rural areas. The PPO choice is diminishing as non-HMO accountable health plans leave the market. • Some plans are willing to offer limited packages to increase affordability. Others are not, because benefit variations complicate plan administration. • Discount card plans are increasingly popular. • Medical savings accounts are getting increased attention. • Many small businesses perceive the statutory mandates to be a disadvantage because they drive rates up to cover benefits the employer might not choose to buy.

Question	Summary of responses
Do small groups get coverage through "associations" under ARS § 20-1401(A)(2)?	Very few. For several reasons: • The requirement of a common purpose other than wanting to get health care insurance is problematic. • Businesses do not want to take on responsibility for the administration, which may be required to keep costs down. • The first associations that formed tended to have unhealthy members, and insurers are wary of the underwriting problems. • Some small employers report that they do not get the benefit of bigger group writing. Carriers sometimes underwrite each employer in the association separately.
Do small groups get coverage through pools under ARS § 20-2313(C)?	None known
Do small groups report concerns about insurers not complying with small group coverage requirements?	Most small employer groups are not familiar enough with the requirements to pinpoint non-compliance, per se. They report actions that have the effect of discouraging them, such as: • Raising the price dramatically between the beginning and the end of the application process. • Insurers declining to quote because they "will not be competitive".

Exhibit C

MARKET CONDUCT ORDERS

ORDERS CITING HIPAA VIOLATIONS

INSURER	STATUTES VIOLATED	VIOLATIONS	DATE OF ORDER	TIME FRAME OF EXAM	CIVIL PENALTY
Blue Cross Blue Shield of Arizona	20-2307, 20-2323	Failed to apply the small group eligibility requirements of the employer. Failed to include a description of the reconsideration process for denied claims and services in disclosure forms.	11/16/01	8/1/99-7/31/00	$8,000
Pacific Life & Annuity Company	20-2307, 20-2309	Failed to provide reasons for rate increases. Declined to add employees and dependents to in-force coverage	9/27/01	10/1/99-9/30/00	$38,000
United of Omaha Life Insurance Company	20-2307, 20-2309	Failed to issue coverage to eligible employees. Postponed coverage until termination of a medical condition. Imposed eligibility standards other than those of the employer. Failed to explain rate increases	8/20/01	8/1/95-7/31/98	$18,000
American Republic Insurance Company	20-1379	Failed to investigate HIPAA guaranteed-issue eligibility of individual applicants	8/17/01	7/1/98-3/31/00	$22,500
Travelers Insurance Company	20-2309	Failed to provide reasons for rate increases	7/3/01	1/1/92-12/31/94	$20,000
Central Reserve Life Insurance Company	20-2307, 20-2309, 20-2311, 20-2313	Refused to cover eligible employees. Canceled group health plan for reasons not allowed by law. Failed to explain rate increases. Discouraged agents from submitting applications based on health status-related factors.	5/16/01	1/1/95-12/31/97	$50,000
Health Plan of Nevada	20-2310	Failed to apply prior creditable coverage to reduce preexisting condition limitations.	5/7/01	8/15/96-12/31/98	$14,000
Conseco Medical Insurance Company	20-1379	Failed to determine if applicants were HIPAA eligible	4/10/01	6/1/99-5/31/00	$26,000
Aetna Life Insurance Company	20-2304	Denied coverage to qualified applicants	3/7/01	1/1/94-4/1/97	$75,000
United States Life Ins. Co. in the City of New York	20-2309	Failed to provide reasons for rate increases	1/18/01	4/15/95-4/14/98	$33,000
Mutual of Omaha Ins. Co.	20-1380	Failed to provide certificates of creditable coverage	12/27/00	8/1/98-7/31/98	$15,000

INSURER	STATUTES VIOLATED	VIOLATIONS	DATE OF ORDER	TIME FRAME OF EXAM	CIVIL PENALTY
Boston Mutual Life Insurance Company	20-2304, 20-2307, 20-2308, 20-2309, 20-2310, 20-2313	Failed to provide the same benefits to employers regardless of group size. Required employer to purchase other forms of insurance as a condition of coverage. Improper termination provisions. Discouraged application of qualified small employer for health coverage and declined to quote groups because of health status-related factors. Limited benefits based on health status related factors. Improperly applied preexisting condition limitations. Excluded adopted children and children placed for adoption as dependents	12/11/00	1/1/95-12/31/97	$30,000
Aetna U.S. Healthcare	20-2309	Failed to provide 60 days notice of premium increases	9/28/00	1/1/94-4/1/97	$45,000
Foundation Health National Life Insurance Co.	20-2309	Failed to provide 60 days notice of renewal terms	8/24/00	1/1/94-3/31/97	$11,000
Intergroup of Arizona	20-2304, 20-2309, 20-2311	Failed to issue coverage to eligible small employer groups. Failed to provide 60 days notice of premium increases and reasons for increases. Failed to disclose rating practices to small employer groups	8/24/00	1/1/94-3/31/97	$50,000
United Wisconsin Life Insurance Company	20-2309, 20-2311	Failed to explain rate increases. Used actuarially unsound rating practices	8/24/00	1/1/95-12/31/97	$48,000
Security Life Insurance Company of America	20-2310	Included waivers of health conditions in a group health plan	7/31/00	1/1/94-2/28/97	$40,000
John Alden Life Insurance Company	20-2309	Failed to explain rate increases at renewal	5/24/00	1/1/94-12/31/96	$45,000

Exhibit D

CIRCULAR LETTERS ON

HIPAA ENFORCEMENT ISSUES

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

JANE DEE HULL
Governor

2910 NORTH 44th STREET, SUITE 210
PHOENIX, ARIZONA 85018-7256

CHARLES R. COHEN
Acting Director of Insurance

Circular Letter 1998-10

TO: Health Insurance Industry Representatives, Insurance Trade Associations, Life & Disability Insurers, and other Interested Parties

FROM: Charles R. Cohen
Acting Director of Insurance

DATE: September 21, 1998

RE: HIPAA Enforcement Issues

Legislation enacted in 1997 by the Arizona State Legislature, together with legislation enacted by the United States Congress in 1996, aim to ensure the availability of health insurance coverage in both the group and individual markets. See Laws 1997, Ch. 251 (SB 1321) and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191; 101 stat. 1936) (HIPAA).

HIPAA guarantees certain consumers the opportunity to purchase health insurance coverage from an indemnity insurer or a health care services organization (collectively "health insurers"). Health insurers who sell health insurance coverage in the small group market must accept every small employer that applies for coverage, including those whose eligible employees have serious medical problems. This same guaranteed issue protection applies to health insurers who sell health insurance coverage in the individual market to HIPAA-eligible individuals. A HIPAA-eligible individual is one who has maintained at least 18 months of health insurance coverage, was most recently covered under a group health plan and has not been without coverage for more than 63 consecutive days.

Regulation of the business of insurance in Arizona is the power and duty of our state government. However, the federal government provided, when it enacted HIPAA, that if a state fails to substantially enforce the provisions of HIPAA, the federal government may enforce HIPAA in that state.

The manner in which health insurers market their products largely determines whether coverage is truly being made available to the public. Traditionally, insurers rely upon producer networks compensated by commissions and other forms of contingent compensation to market their products. The Department has learned that some health insurers in Arizona have reduced or eliminated the payment of commissions to producers for policies sold to high-risk small groups and to individuals eligible for HIPAA-related coverage. The elimination or reduction in commissions for these coverages has been accomplished in several ways. Some health insurers have tied the commission decrease to the number of employee lives in the group. Others have tied the elimination or reduction of commissions to the percentage increase in premium over the standard premium. Still others have eliminated commissions to agents for products offered or sold to high-risk small groups and to individuals eligible for any HIPAA-related coverage.

Earlier this year, at the urging of the President of the United States, the Department of Health and Human Services, through the Health Care Financing Administration, issued a program memorandum that states, in part:

> We have become aware that some issuers are attempting to discourage the offering of policies to HIPAA eligible individuals in the individual market, or to small groups containing high risk individuals, by withholding commissions from agents for sales to such individuals or small groups. Agents have sent us copies of notices from a number of issuers stating they will not pay or will reduce commissions and bonuses for sales to high risk groups and/or HIPAA eligible individuals. If an issuer pays agents less through all forms of agent compensation (commissions, bonuses, or other awards) for high risk individuals and groups than it pays for those with better risk profiles, this act constitutes a circumvention of the insurance reform provisions of HIPAA.
>
> • • •
>
> The guaranteed issue provisions of the statute generally require that issuers' normal conduits for receiving applications and offering coverage be open to HIPAA-eligible individuals or small employers. Issuers commonly use agents as an important part of their marketing and distribution system, and ordinarily compensate these agents by paying commissions on the coverage they sell. Commission payment is included among the costs used to calculate the premium rate for a given form of coverage. For an issuer to modify the normal operation of its marketing and distribution system so as not to attract its fair share of the high risk individuals and small groups protected by

> HIPAA does not accord with the intent of the statute to protect these individuals and groups. . . .
>
> The Department concurs with HCFA's reasoning.

The legislation presumed that health insurers would continue to genuinely utilize their producer networks to sell health insurance coverage to HIPAA protected individuals and groups just as they do to sell other coverages in the market. If producers receive reduced or no compensation for their production efforts related to the sale of health insurance coverage to HIPAA eligible individuals or small groups, producers will have reduced incentive to serve these populations. The consequence will be to deprive consumers of access to the health insurance coverage that the Legislature and the Congress intended to be made available on a guaranteed issuance basis to individuals and small groups. In short, a health insurer that reduces or eliminates compensation to its producer force for the sale of these guaranteed issue products to discourage marketing to HIPAA-eligible individuals and small groups effectively fails to provide "guaranteed availability" consistent with the requirements of both state and federal law.

We are also concerned that the reduction or elimination of compensation for guaranteed availability products by one health insurer has the effect of unfairly shifting the burden of guaranteed availability to competing health insurers who honor the spirit and intent of the law.

The Department urges health insurers to adhere to the spirit and intent of HIPAA and SB 1321. Failure to compensate producers of guaranteed availability products consistently with producers of similar lines of insurance violates, at least, the spirit of these laws. Moreover, this conduct may constitute unfair competition, unfair discrimination or other violations of the insurance code. The Department will carefully evaluate, on a case-by-case basis, the appropriateness of enforcement action against any health insurer that fails to act in compliance with the law and the purpose that this law was intended to achieve.

Should you have questions relative to this circular letter, please direct them to Mary Butterfield (602) 912-8460.

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

JANE DEE HULL
Governor

2910 NORTH 44th STREET, SUITE 210
PHOENIX, ARIZONA 85018-7256

CHARLES R. COHEN
Director of Insurance

CIRCULAR LETTER 2000-1

TO: All Health Care Insurers, Health Care Service Organizations, Hospital Service Corporations, Medical Service Corporations, Dental Service Corporations, Optometric Service Corporations, Insurance Trade Associations and Interested Parties

FROM: Charles R. Cohen
Director of Insurance

DATE: January 6, 2000

RE: **Issuers' Affirmative Obligations Under the Health Insurance Portability and Accountability Act (HIPAA)**

The purpose of this circular is to remind companies selling health care insurance in the individual market ("issuers") of their affirmative obligation to identify and timely respond to Eligible Individuals under the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA requires issuers to provide guarantee issue of an individual health insurance policy to Eligible Individuals[1]. Under HIPAA, an issuer cannot deny coverage to an Eligible Individual. In Section III of the attached Program Memorandum, the Health Care Financing Administration (HCFA) has unambiguously placed the responsibility for identifying Eligible Individuals upon issuers. As noted in the attached memorandum, a prospective insured need not refer to HIPAA nor use any specific terminology such as "guaranteed issue" to trigger the issuer's obligation. Whenever a prospective customer who may potentially be an Eligible Individual contacts an issuer or its agent, the issuer and its agents have an affirmative obligation to advise the customer of HIPAA and the right to guaranteed issuance of a policy.

The Department is concerned that some issuers may be avoiding this affirmative obligation. To date, although there are approximately 35 companies doing business in the individual market, only three companies issued the majority of HIPAA policies issued in 1998. These three companies issued 2587 of the 2813 policies sold to Eligible Individuals. The Department expects 1999 figures to follow the same trend. These disparate numbers suggest that some issuers are not making HIPAA policies readily

[1] An Eligible Individual is a person having 18 months of creditable coverage, the most recent of which is group, without any breaks in coverage longer than 63 days, and who has no right to other insurance.

available to prospective insureds. Some issuers may be using a variety of techniques to discourage prospective Eligible Insureds, such as refusing to quote rates over the phone, making exaggerated statements about the high cost of HIPAA policies, requiring customers to specifically refer to HIPAA or guaranteed issue before volunteering any information, requiring the customer to write in for more information, and delaying the transmittal of requested information. As noted in the attached Program Memorandum, such techniques are not allowed and will subject the issuer to sanctions for failure to comply with HIPAA and corresponding state law.

To determine whether an issuer is complying with its affirmative obligation under HIPAA, the Department will closely examine the issuers' practices, particularly in comparison to how the issuer responds to prospective insureds who are not Eligible Individuals. The Department will look at the issuer's materials for training staff on HIPAA's requirements, and its policy and procedures for eliciting factual information to determine potential HIPAA eligibility and responding to customer inquiries. The Department will examine the issuer's methods for responding to customer requests for information about HIPAA policies and whether those practices differ from the methods used for other types of individual policies. For example, if the issuer will telephonically quote rate information for non-HIPAA policies, the Department will expect the issuer to do so for HIPAA policies. The Department will examine the ease with which an issuer makes information available to HIPAA eligibles in comparison to other individuals, and also the time periods for transmittal of information. The Department will look at whether there is unreasonable delay in providing information and guidance on HIPAA policies, following a request.

The Department encourages all issuers selling in the individual market to make any changes necessary to ensure that the issuer promptly identifies Eligible Individuals and does not delay or impede the individual's ability to exercise the right to guaranteed issuance of an individual health insurance policy. Companies found to be out of compliance with the obligations discussed in this circular will be subject to appropriate regulatory action, which may include applicable civil penalties.

STATE OF ARIZONA

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CHARLES R. COHEN
Director of Insurance

Circular Letter 2000-7

TO: Life and Disability Insurers, Agents and Brokers, Health Care Services Organizations, Insurance Trade Associations, and Other Interested Parties

FROM: Charles R. Cohen
Director of Insurance

DATE: May 19, 2000

RE: **Right to Guaranteed Issue Under the Health Insurance Portability and Accountability Act of 1996**

The purpose of this circular letter is to clarify certain requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing state law at A.R.S. § 20-1379 and 20-2301 et seq.

No Age Limitations

The Department has learned that some insurers have denied the right to guaranteed issuance of health insurance policies to HIPAA eligible individuals aged 19 or younger. These denials appear to be based solely on the age of the applicant.

Every health care insurer offering coverage in the individual market is required to guarantee the issuance of coverage to HIPAA eligible individuals in accordance with the provisions of A.R.S. § 20-1379. The definition of eligible individual in A.R.S. § 20-1379(P) has no requirement that a person be of a particular age. Nothing in the law precludes a person age 19 or younger from being an eligible individual if that person meets the statutory criteria and would otherwise be entitled to the guaranteed issuance of coverage.

Insurers may not deny coverage to eligible individuals based on the age of the applicant, including child-only applicants. Any provision in an application, policy, or evidence of coverage that attempts to limit the right to guaranteed issue on the basis of the individual's age is unenforceable as to an eligible individual who otherwise meets the requirements of A.R.S. § 20-1379(P).

Prohibitions on Non-Confinement Clauses

The Health Care Financing Administration (HCFA) has issued a program memorandum (Transmittal no. 00-01, dated March 2000) regarding the application of non-confinement clauses to HIPAA eligible individuals.[1]

Health insurance policies often contain what are commonly referred to as "non confinement clauses" or "deferral rules." Under these provisions, if an individual is an inpatient on the day that coverage is scheduled to take effect, the individual is not entitled to any insurance benefits until the first day after the individual is no longer an inpatient. HCFA's bulletin provides that such attempts to delay the effective date of coverage violate HIPAA.

According to HCFA's bulletin, delaying the effectiveness of coverage due to an individual's hospital confinement violates the Public Health Service Act (PHS) , as added by Title I of HIPAA. For persons in a group, the delay is tantamount to a denial of eligibility based on a health factor, which is prohibited by the non-discrimination provisions of PHS § 2702. In addition, the non-confinement clause operates to exclude pre-existing conditions by precluding coverage of benefits related to a pre-existing condition, in violation of PHS § 2701 (as to persons in a group) and § 2741 (as to eligible individuals).

Arizona has provisions that mirror the prohibitions found in HIPAA. (See A.R.S. § 20-2310(A) and (B) (persons in groups) and A.R.S. § 20-1379 (eligible individuals).) The Insurance Department interprets these provisions in accordance with the HCFA bulletin, and will enforce these provisions against insurers doing business in Arizona. All health insurance issuers selling group or individual health insurance coverage must ensure that the evidence of coverage or policy does not include or attempt to apply a non-confinement clause as to persons in groups or eligible individuals.

Questions regarding this circular should be directed to Mary Butterfield, Assistant Director, Division of Life and Health, 602/912-8443.

[1] A copy of the bulletin is available through HCFA's web site on HIPAA at www.hcfa.gov/medicaid/hipaa; click on the box for "bulletins." Alternatively, you may also find the bulletin through HCFA's home page at www.hcfa.gov After arriving at the home page, type "Insurance Standards Bulletin" in the "search" box. At that site, click on "Bulletin: HI00-01."

Exhibit E

SURVEY REGARDING SMALL GROUP LAWS IN OTHER STATES

State	Survey Questions* A	B	C	D	Comments
1. Alabama	No	No	No	Yes	
2. Arkansas	No	No	No	Yes	
3. Connecticut	No	Yes	No	Yes	Reinsurance pool structured similarly to Arizona's. Five year market suspension if insurer withdraws from market.
4. District of Columbia	No	No	No	No	
5. Idaho	No	Yes	No	Yes	Insurer is only eligible to market to small employers and participate in reinsurance program if they have filed a guaranteed issue product. They have option not to do so. All small group insurers subject to reinsurance program assessments, so all have elected to be reinsuring carriers.
6. Illinois	No	No	No	Yes	No specific small group laws other than a small group rating act. They have experienced same loss of small group carriers as most other states have.
7. Indiana	No	Yes	No	Yes	Of 60 small group insurers only 15 participate in the reinsurance pool. The reason for the poor participation is not known. As a result of HIPAA guaranteed availability requirements the number of small group insurers has declined by approximately 30%.
8. Kansas	No	No	No	Yes	Adopted small employer group insurance laws and reinsurance pool in 1992, however, repealed all in 1998. Enacted law requiring small employer insurers to povide coverage on guaranteed issue basis. Legislation adopted in 2000 allows small employers a refundable tax credit for 5 years for providing health insurance to their employees. Since 1995 approximately 30 insurers writing small employers have withdrawn from market.
9. Minnesota	No	No	No	No	Have task force that has looked into possible small employer reforms and will discuss with legislature during next session. Some suggested reforms are a rate increase cap of 15% plus trend, elimination of premium taxes and assessments and eliminate cap on HMO deductibles. The Blues and two HMOs control 80% of market, with 10 indemnity carriers sharing remaining 20%.
10. Nevada	No	Yes	No	Yes	Insurers must elect to be reinsuring carrier to participate in reinsurance pool.
11. New Jersey	No	No	No	Yes	Insurers that choose to participate in small employer market are required to offer standardized plans developed by a State Board on a guaranteed issue basis.
12. North Carolina	No	Yes	No	Yes	
13. Rhode Island	No	No	No	No	Nearly all of small employer market is served by the Blues and one other carrier.
14. South Dakota	No	No	No	Yes	Had some small employer laws, but repealed them when HIPAA laws adopted as they saw no need for them in light of HIPAA guaranteed issue requirements.
15. Texas	No	Yes	No	Yes	Insurer may choose to offer to small groups or not. Small group insurers must offer at least two required plans on guaranteed issue basis and may elect to re reinsuring carrier.
16. Utah	No	No	No	Yes	State legislature looking at possibility of some type of premium tax exemption.
17. Virginia	No	No	No	Yes	Insurers in small employer market required to offer at least a standard plan on a guaranteed issue basis.
18. Wyoming	No	Yes	No	No	Only 13 small employer insurers, down 46% from a year ago.
"Yes" Percent of Total	**0%**	**40%**	**0%**	**73%**	
"No" Percent of Total	**100%**	**60%**	**100%**	**27%**	

***Legend**

A. Does the state have a law that requires group health insurers to offer at least on plan to small employers on a guaranteed issue basis if they offer plans to medium or large employers?

B. Does the state have a small employers reinsurance program open to all group health insurers?

C. Does the state have a premium tax exemption from small employers group health insurance premiums?

D. Does the state have specific notice requirements for termination of small group coverage?

Notes

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